STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. BUILDING _____ B. WING _____	C 06/05/2015

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WOODMONT CENTER	PO BOX 419 11 DAIRY LANE FREDERICKSBURG, VA 22404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 6/4/15 through 6/5/15. One complaint was investigated during the survey. Significant Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 118 certified bed facility was 105 at the time of the survey. The survey sample consisted of 2 current Residents reviews (Residents #2 and #3) and one closed record review, Resident #1. .	F 000	RECEIVED JUN 25 2015 VDH/OLC This is our facility's Allegation of Compliance. Woodmont Center does not admit or deny the existence of the alleged deficiencies. Woodmont Center maintains that it is in substantial compliance and the Plan of Correction below will be completed by	
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as	F 157	Karen S. Green 7/ 10 /2015 Karen S. Green Date Administrator **F 157** **SS=G** Resident #1 was discharged back to Mary Washington Hospital by order obtained from L. Troxler, NP, and resident #1 was transferred to hospital at 7:59 pm on 5/25/15. Other residents with wound care orders and the potential to be negativity affected by the same deficient practice have been assessed by our NP and Wound Nurse to rule out any negative status caused by the same deficient practice. All current	7-10-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen S. Green — TITLE: Administrator — (X6) DATE: 6-24-15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined the facility staff failed to notify and consult with the residents physician regarding the wound status upon admission and prior to changing wound care treatment orders for one of three resident's in the survey sample, Resident #1. Resident #1 was admitted to the facility on 5/22/15 with orders for a wound vac (vacuum) (negative pressure wound therapy). The facility staff failed to notify and consult with the resident's surgeon or a physician regarding the wound status upon admission and prior to changing the treatment orders for Resident #1's new skin graft. The wound vac was not placed on the graft as ordered by the physician and the skin graft developed necrotic (dead) tissue. On 5/25/15 Resident #1 was sent to the local emergency room and readmitted to the hospital and required surgical removal of the graft that was totally necrotic. Negative pressure wound therapy is not a new concept in wound therapy. It is also called sub atmospheric pressure therapy, vacuum sealing,	F 157	residents with physician wound orders were being followed correctly as written and no negative wound status was found. RN #1 and RN 2nd Shift Supervisor received one on one education by the facility Administrator and Director of Nursing on the necessity for carrying out Surgeon/MD admission wound care orders and the importance of timely notification with all Surgeons/MDs of wound care residents concerning wound care negative status immediately by the resident's nurse. Licensed Nurses are being in-serviced by our RN Nurse Practice Educator and RN Quality Assurance Nurse/Designee on the practice of following Surgeon orders for wound care and the importance of keeping the Surgeon/MD informed of any negative wound changes immediately and promptly begin any order changes that the Surgeon/MD may make. RN ADONs/RN Administrative Nurses will audit daily all wound care	7-10-15 7-10-15 7-10-15

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F 157	Continued From page 2 vacuum pack therapy and sealing aspirative therapy. The aim of the procedure is to use negative pressure to create suction, which drains the wound of exudate (i.e., fluids, cells and cellular waste that has escaped from blood vessels and seeped into tissue) and influences the shape and growth of the surface tissues in a way that helps healing. During the procedure, a piece of foam is placed over the wound, and a drain tube is placed over the foam. A large piece of transparent tape is placed over the whole area, including the healthy tissue, to secure the foam and drain the wound. The tube is connected to a vacuum source, and fluid is drawn from the wound through the foam into a disposable canister. Thus, the entire wound area is subjected to negative pressure. The device can be programmed to provide varying degrees of pressure either continuously or intermittently. It has an alarm to alert the provider or patient if the pressure seal breaks or the canister is full. Negative pressure wound therapy may be used for patients with chronic and acute wounds; sub acute wounds (dehisced incisions); chronic, diabetic wounds or pressure ulcers; meshed grafts (before and after); flaps. It should not be used for patients with fistulae to organs/body cavities, necrotic tissue that has not been debrided, untreated osteomylitis, wound malignance, wounds that require homeostasis or for patients who are taking anticoagulants." (1) The findings include: Resident #1 was admitted to the facility on 5/22/15 at 7:00 p.m. with diagnoses that included but were not limited to: lower limb amputation (fourth and fifth toe of the right foot), status post skin graft to right foot, diabetes, high blood pressure, elevated cholesterol, and morbid obesity.	F 157	patients and charts admitted and existing residents with wounds for detection of irregularities in nurses being compliant with Surgeon/MD orders and informing them of any negative wound status immediately. Any irregularities found will be corrected immediately by the resident's nurse with the oversite of the RN auditors to restore compliance with the physician's orders. The audit findings will be recorded daily on the RN Wound Care Audit logs for compliance with physician orders. The Audit logs will be reviewed for three months during the facility's monthly QA Committee meeting for compliance with this plan of correction.	7-10-15 7-10-15

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F 157	Continued From page 3 The discharge MDS (minimum data set) assessment, with an assessment reference date of 5/25/15, coded the resident as requiring limited assistance for moving in the bed. The resident required extensive assistance for transferring from surface to surface, toileting needs and personal hygiene. The Resident #1 was coded as dependent on the staff for dressing and bathing. The "Pre-Admission Report (PAR)" was completed by the nursing home corporate nurse liaison at the hospital, on 5/22/15 at 11:49 a.m. The PAR documented, "Surgical Procedure: Amputation of the 4th and 5th metatarsals (toes) and digit, right foot with skin graft to lateral aspect of the right foot after resection to promote healing. Complications: No complications noted. Wound Care: 1. Wound care needs - Yes. 2. Negative Pressure (wound vac) - Yes. 2a. Date Negative Pressure started - 5/16/15. 2b. Settings - 125 mmhg (millimeters of mercury). 3. Wound care type - surgical. 3c. Body Location/Description/Treatment - Right foot amputation and graft sites." The "(Name of Hospital) Discharge Instructions" dated, 5/22/15, documented, "Discharge Needs: Durable Medical Equipment: Other - (Name of wound vac company). Durable Medical Equipment Type: Other - wound vac." The "Discharge Instructions" were electronically signed by the physician on 5/22/15 and electronically signed by the discharging nurse on 5/22/15. The Hospital "External Facility Transfer Form" dated, 5/22/15, documented, "Musculoskeletal: Non-weight bearing RL (right leg). Mobility Comms (comments): pt (patient) s/p (status post) amputee R (right) foot 4th and 5th toe wound vac and dressing intact."	F 157		

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F 157	Continued From page 4 The nursing admission assessment, dated 5/22/15 at 1900 (7:00 p.m.), written by RN (registered nurse) #1, documented the resident was alert and oriented to person, place and time. The form documented, "Physician notified of admission/readmission and orders verified?" The circle next to "Yes" was filled in. In Section & - Integumentary (skin) the following was documented: "d5. Site: Open area present on top of right foot 2 x 2 cm (centimeters) with slough present. d6. Site: Rt (right) foot amputation site 10 x 3.5 cm with skin graft and 13 sutures. d7. Site: Necrotic area present to tip of right 3rd toe. d8. Site: Necrotic area present to right lateral heel 1.5 x 1.5 cm. d9. Site: Necrotic area present to right medial heel 1 x 0.8 cm." Under the Section "Other Devices currently used" the circle for "No" was filled in next to, "Wound vac/negative pressure present?" The admission physician orders dated, 5/22/15, no time documented, "Cleanse amputation site to R lateral foot W/NS (with normal saline); apply Oil emulsion gauze drsg (dressing) daily - monitor daily." Review of the treatment administration record (TAR) documented, "Cleanse amputation site to R lateral foot W/NS (with normal saline); apply Oil emulsion gauze drsg (dressing) daily." The treatment was documented as being done for 5/22/15 through 5/25/15. The nurse's notes dated, 5/22/15 at 1900 documented, "Resident admitted/readmitted to (room #). Arrived by ambulance and stretcher. Information upon admission obtained from patient chart. Reason for admission is post-survey recent acute illness Rehabilitation...Call bell	F 157		

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F 157	Continued From page 5 placed within reach. Physician notified/orders verified: Yes. See nursing admission assessment for detailed clinical findings." Written by RN (registered nurse) #1. The comprehensive care plan, dated, 5/22/15, documented, "Focus: Resident has actual skin breakdown related to shear/friction risks, vascular disease, limited mobility." The "Interventions" documented, "Evaluate wound area daily including surrounding tissue and presence or absence of drainage/infection and/or new wound pain and report to MD (medical doctor) as indicated. Monitor for effectiveness and/or side effects of medication. Monitor for verbal and nonverbal signs of pain related to wound or wound treatment and medicate as ordered." The "Skin Integrity Report" dated, 5/22/15, documented "Surgical" and documented for the right lateral foot surgical wound the following: "Presence of Pain - no Appearance - skin graft, 13 sutures, IP (intact/deep purple) deep red. Length - 10 (centimeters) Width - 3.5 Depth - na (not applicable) Drainage - na/ dry Surrounding tissue - IF/DP (inflamed/deep purple-maroon) Wound Edges - M (macerated) Odor - no." The "Skin Integrity Report" dated, 5/25/15, documented for the right lateral foot surgical wound the following: "Presence of Pain - no Appearance - N (necrotic - eschar) with sutures in place Length - 10 (centimeters) Width - 3.5 Depth - left blank	F 157		

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F 157	Continued From page 6 Drainage - na Surrounding tissue - IF (inflamed) Odor - (a zero with a line through it indicating 'no')." The nurse's note dated, 5/25/15 at 19:59 (7:59 p.m.) documented, "(Resident #1) transferred to hospital - unplanned for evaluation and treatment via ambulance to (initials of hospital) ER (emergency room). Physician notified of transfer (nurse practitioner name) 5/25/15 - 8 p.m. Responsible party notified of transfer Self/Daughter 5/25/15 at 8 p.m. Resident admitted to facility for right 4th/5th toes amputation with graft placement due to gangrene. Upon admission, graft site noted to be deep red/purple and to be somewhat dry. Over the weekend condition of wound worsened and is now noted to have layer of necrosis. Resident denies feeling pain (due to neuropathy). New orders to send resident to hospital for evaluation. Resident also on Zosyn (an antibiotic) and Vancomycin (an antibiotic) IV (intravenous) therapy." The nurse's note dated, 5/25/15 at 20:46 (8:46 p.m.) documented, "(Name of doctor who did skin graft - administrative staff member [ASM] #3, podiatrist) returned the call after the patient had been transferred out to the hospital. He was told that the wound vac had not been applied. (ASM #3, podiatrist) reminded writer that he had signed all the paperwork for the wound vac. (ASM #3) was also told that (the infectious disease physician) had been faxed the lab (laboratory) results showing that the Creatinine level (indicating kidney function) was above 1.6 showing 1.63. (Name of nurse practitioner) had been called and made aware that RP (responsible party) was upset. Order was given to send the pt (patient) to (initials of hospital) ER	F 157		

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F 157	Continued From page 7 for eval (evaluation)." The ER physician report dated, 5/25/15 at 20:59 (8:59 p.m.) documented, "Chief Complaint: complication with graft from gangrene. Severity is described as being, it has become recently worse. This started 2 days ago and is still present. Symptoms located in the area of the right root. The patient had not had redness. No swelling. Patient denies injury. Additional history - 64 year old female presents to ED (emergency department) from (Name of nursing facility) via EMS (emergency medical services) d/t (due to) possible graft necrosis x1 day. Pt had right 4th and 5th toes removed and a graft placed on 5/23/15 (*note this date is a discrepancy as the resident was discharged to the facility on 5/22/15 post placement of the graft) d/t gangrene. Pt reports bleeding x2 days from site and today the staff at (name of nursing home) noted a change in status of the wound. Pt reports she has not been on a wound vac since she was dc'd (discharged) from the hospital...Temp (temperature): 100.6 (normal is 98.6)." The attending physician history and physical dated 5/25/15, documented, "History of present illness: The patient was discharged from the hospital on 5/22/15 after coming in with cellulitis and gangrene of the right foot, it was found that she had osteomyelitis (infection of the bone) involving the right 4th and 5th toes post amputation. (ASM #3, the podiatrist) removed the 4th and 5th toes and performed some skin grafting over the proximal area of the right foot due to inability to have full closure. The patient stated that she was supposed to have a wound VAC placed on her foot, although that never did occur and today when the wound nurse came in to do wound care, she noted that the skin graft had died, so the patient requested to be	F 157		

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F 157	Continued From page 8 transferred to the hospital." The "Consultation Note" dated, 5/26/15, by ASM #3, the podiatrist, documented, "The patient is a 64 year-old, white female, who had an amputation of the 4th and 5th metatarsals (toes) of the right foot with skin graft placement last week. She was placed in (name of facility) on Friday. The Nursing Home decided not to place the wound VAC over the wound. Yesterday evening, she was admitted here with total necrosis of the graft at the lateral aspect of her right foot...Plan: Total debridement (surgical removal of devitalized tissue*) of the wound was discussed with the patient with placement of a new wound VAC. She is scheduled for the operating room tomorrow at 1:30 p.m." An interview was conducted with RN #1 on 6/4/15 at 3:02 p.m. When asked if Resident #1 came in with orders for a wound vac, RN #1 stated, "No, there were no orders for a wound vac." RN #1 was asked if she was aware of the resident's needs for a wound vac and that she had a skin graft. RN #1 stated, "The wound nurse alerted me that a resident was coming with a graft site. I evaluated the resident per our protocol for graft sites. The site was dry, deep, deep red with purple spots. My understanding is that a wound vac is put on nice healthy tissue. So I put on the oil emulsion dressing." When asked if she is certified in wound care, RN #1 stated, "No, the wound care nurse instructed me." When asked if she called a doctor to get those orders for the emulsion dressing, RN #1 stated, "No, we have orders to initiate treatment per our protocol." When asked if she contacted the surgeon that did the skin graft, to inform him/her of the status of the wound, RN #1 stated, "No, I had a really busy night that night." An interview was conducted with ASM #3, the	F 157		

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F 157	Continued From page 9 podiatrist who performed the amputation and skin graft, on 6/4/15 at 3:45 p.m. When asked if he had written out orders for the wound vac, ASM #3 stated, "The discharging physician writes the orders. I worked with the continuing care nurse at the hospital to fill in the forms for her insurance company to approve the wound vac. Everything was set in place with (name of manufacturing company of wound vacs). It was supposed to be at the facility when she arrived. The patient knew she was supposed to have a wound vac." ASM #3 was asked what knowledge he had of Resident #1's time at the facility. ASM #3 stated, "I spoke with a nurse on Monday (5/25/15) from the facility, (RN #2, the evening supervisor). She told me that the resident had orders for the wound vac and she doesn't know why the nurse didn't follow the orders. I saw the wound on Friday (5/22/15) morning. It had nice pink viable tissue; the granulation tissue was forming through the mesh. I had a wound vac on her for one week and it was doing great in the hospital. Why it was black on Monday night is from the wound vac not being applied as ordered. If they had a question about the wound, wouldn't you think they would contact the operating surgeon? Shouldn't they contact me and tell me my orders were changed? I had to take her back to the operating room to debride the graft and placed another wound vac. She will now have a recovery time of four months instead of four weeks. I am so concerned that no one called me. I am on call. I have an answering service. I take my own call unless I am out of town, I wasn't. There was no reason why I should not have been contacted." On 6/4/15 at 4:04 p.m. RN #1 returned to this surveyor and stated, "I misunderstood what you asked. Every time I get orders we have to go through our doctors." When asked who she	F 157		

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F 157	Continued From page 10 spoke with on 5/22/15 when Resident #1 arrived at the facility, RN #1 stated, "(Name of ASM #4 {on call physician}). If I don't talk to the doctor's then my supervisor does." When asked who spoke with ASM #4 on 5/22/15, RN #1 stated, "I talked to the on call doctor, (ASM #4)." On 6/4/15 at 4:08 p.m. an interview was conducted with the director of nursing (DON). The DON was asked what interactions or knowledge she had of Resident #1. The DON stated, "I was here on Memorial Day for a little bit. I answered her call bell and assisted her toileting and helped dress her. I didn't have any knowledge of the wound situation." When asked if RN #2, the evening supervisor, was available for interview, the DON stated RN #2 (evening supervisor) was out of the country on vacation. When asked if any nurse practitioner or doctor examined Resident #1's wounds prior to 5/25/15, the DON stated, "No." The on-call schedule for the physicians was reviewed for the month of May 2015. The nurse practitioner was documented as on call on 5/22/15, 5/23/15, 5/24/15 and 5/25/15. An interview was conducted with ASM #4, (the physician that RN #1 stated she had spoken to on 5/22/15), on 6/5/15 at 8:30 a.m. When asked if she was on call on 5/22/15, ASM #4 stated, "I don't think so." When asked if she recalled being on call for Memorial Day weekend, ASM #4 stated, "No, I was off that weekend." ASM #4 was asked when her on call rotation starts. ASM #4 stated, "On Friday after 5:00 p.m." ASM #4 was then asked if she recalled a conversation with RN #1 on 5/22/15 regarding Resident #1's wound, a skin graft. ASM #4 stated, "I don't do wounds at all. I usually don't do any orders for them; the facility takes care of that." When asked what she does when there is any complicated wound, ASM	F 157		

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F 157	Continued From page 11 #4 stated, "I talk to the Medical Director." ASM #4 was asked if the nurse brought to her attention a surgical wound concern, would she contact the surgeon who performed the surgery. ASM #4 stated, "Yes, if there is a concern with a surgical wound I would have them contact the surgeon." The facility policy, "Physician/Med-level Provider Notification" documented, " Upon identification of a patient who has a change in condition or abnormal lab (laboratory) values, a licensed nurse will perform appropriate clinical observations and data collection and report to physician/mid -level provider. If unable to contact attending physician/mid-level, the Medical Director will be contacted. Purpose: To communicate a change in patient's condition to physician/mid-level provider and initiate interventions as needed/ordered. " On 6/5/15 at 9:28 a.m. the DON was informed of above concerns. The administrator was not in the building at that time. When offered the time to present any further information regarding the above concern, the DON stated, "I don't have anything else to present." In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient.	F 157		

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F 157	Continued From page 12 No further information was provided prior to exit. COMPLAINT DEFICIENCY (1)http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3379164/ *This information was obtained from the website: http://www.merriam-webster.com/dictionary/debridement	F 157		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to follow physician orders resulting in harm for one of three residents in the survey sample, Resident #1. Resident #1 was transferred from the hospital on 5/22/15 with orders for a wound vac (vacuum) (negative pressure wound therapy). The facility did not place the wound vac on the resident's new skin graft and the graft developed necrosis or dead tissue. On 5/25/15 Resident #1 was sent to the local emergency room for evaluation and treatment of the necrotic graft site, and was readmitted to the hospital and required surgical	F 309	**F 309** **SS=G** Resident #1 was discharged back to Mary Washington Hospital by order obtained from L. Troxler, NP, and resident #1 was transferred to hospital at 7:59 pm on 5/25/15. Other residents with wound care orders and the potential to be negativity affected by the same deficient practice have been assessed by our NP and Wound Nurse to rule out any negative status caused by the same deficient practice. All current residents with physician wound orders were being followed correctly as written and no negative wound status was found.	7-10-15

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F 309	Continued From page 13 removal of the graft that was totally necrotic. Negative pressure wound therapy is not a new concept in wound therapy. It is also called sub atmospheric pressure therapy, vacuum sealing, vacuum pack therapy and sealing aspirative therapy. The aim of the procedure is to use negative pressure to create suction, which drains the wound of exudate (i.e., fluids, cells and cellular waste that has escaped from blood vessels and seeped into tissue) and influences the shape and growth of the surface tissues in a way that helps healing. During the procedure, a piece of foam is placed over the wound, and a drain tube is placed over the foam. A large piece of transparent tape is placed over the whole area, including the healthy tissue, to secure the foam and drain the wound. The tube is connected to a vacuum source, and fluid is drawn from the wound through the foam into a disposable canister. Thus, the entire wound area is subjected to negative pressure. The device can be programmed to provide varying degrees of pressure either continuously or intermittently. It has an alarm to alert the provider or patient if the pressure seal breaks or the canister is full. Negative pressure wound therapy may be used for patients with chronic and acute wounds; sub acute wounds (dehisced incisions); chronic, diabetic wounds or pressure ulcers; meshed grafts (before and after); flaps. It should not be used for patients with fistulae to organs/body cavities, necrotic tissue that has not been debrided, untreated osteomylitis, wound malignance, wounds that require homeostasis or for patients who are taking anticoagulants." (1) The findings include: Resident #1 was admitted to the facility on 5/22/15 at 7:00 p.m. with diagnoses that included	F 309	RN #1 and RN 2nd Shift Supervisor received one on one education by the facility Administrator and Director of Nursing on the necessity for carrying out Surgeon/MD admission wound care orders and the importance of timely and open communication with all Surgeons/MDs of wound care residents concerning wound care negative status immediately by the resident's nurse. Licensed Nurses are being in-serviced by our RN Nurse Practice Educator and RN Quality Assurance Nurse/Designee on the practice of following Surgeon orders for wound care and the importance of keeping the Surgeon/MD informed of any negative wound changes immediately and promptly begin any order changes that the Surgeon/MD may make. RN ADONs/RN Administrative Nurses will audit daily all wound care patients and charts admitted and existing residents with wounds for detection of irregularities in nurses being compliant with Surgeon/MD orders and informing them of any negative wound status immediately.	7-10-15 7-10-15 7-10-15

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F 309	Continued From page 14 but were not limited to: lower limb amputation (fourth and fifth toe of the right foot), status post skin graft to right foot, diabetes, high blood pressure, elevated cholesterol, and morbid obesity. The discharge MDS (minimum data set) assessment, with an assessment reference date of 5/25/15, coded the resident as requiring limited assistance for moving in the bed. The resident required extensive assistance for transferring from surface to surface, toileting needs and personal hygiene. The Resident #1 was coded as dependent on the staff for dressing and bathing. The "Pre-Admission Report (PAR)" was completed by the nursing home corporate nurse liaison at the hospital, on 5/22/15 at 11:49 a.m. The PAR documented, "Surgical Procedure: Amputation of the 4th and 5th metatarsals (toes) and digit, right foot with skin graft to lateral aspect of the right foot after resection to promote healing. Complications: No complications noted. Wound Care: 1. Wound care needs - Yes. 2. Negative Pressure (wound vac) - Yes. 2a. Date Negative Pressure started - 5/16/15. 2b. Settings - 125 mmhg (millimeters of mercury). 3. Wound care type - surgical. 3c. Body Location/Description/Treatment - Right foot amputation and graft sites." The "(Name of Hospital) Discharge Instructions" dated, 5/22/15, documented, "Discharge Needs: Durable Medical Equipment: Other - (Name of wound vac company). Durable Medical Equipment Type: Other - wound vac." The "Discharge Instructions" were electronically signed by the physician on 5/22/15 and electronically signed by the discharging nurse on 5/22/15. The Hospital "External Facility Transfer Form"	F 309	Any irregularities found will be corrected immediately by the resident's nurse with the oversite of the RN auditors to restore compliance with the physician's orders. The audit findings will be recorded daily on the RN Wound Care Audit logs for compliance with physician orders. The Audit logs will be reviewed for three months during the facility's monthly QA Committee meeting for compliance with this plan of correction.	7-10-15 7-10-15 7-10-15

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F 309	Continued From page 15 dated, 5/22/15, documented, "Musculoskeletal: Non-weight bearing RL (right leg). Mobility Comms (comments): pt (patient) s/p (status post) amputee R (right) foot 4th and 5th toe wound vac and dressing intact." The nursing admission assessment, dated 5/22/15 at 1900 (7:00 p.m.), written by RN (registered nurse) #1, documented the resident was alert and oriented to person, place and time. The form documented, "Physician notified of admission/readmission and orders verified?" The circle next to "Yes" was filled in. In Section & - Integumentary (skin) the following was documented: "d5. Site: Open area present on top of right foot 2 x 2 cm (centimeters) with slough present. d6. Site: Rt (right) foot amputation site 10 x 3.5 cm with skin graft and 13 sutures. d7. Site: Necrotic area present to tip of right 3rd toe. d8. Site: Necrotic area present to right lateral heel 1.5 x 1.5 cm. d9. Site: Necrotic area present to right medial heel 1 x 0.8 cm." Under the Section "Other Devices currently used" the circle for "No" was filled in next to, "Wound vac/negative pressure present?" The admission physician orders dated, 5/22/15, no time documented, "Cleanse amputation site to R lateral foot W/NS (with normal saline); apply Oil emulsion gauze drsg (dressing) daily - monitor daily." Review of the treatment administration record (TAR) documented, "Cleanse amputation site to R lateral foot W/NS (with normal saline); apply Oil emulsion gauze drsg (dressing) daily." The treatment was documented as being done for 5/22/15 through 5/25/15. The nurse's notes dated, 5/22/15 at 1900	F 309		

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F 309	Continued From page 16 documented, "Resident admitted/readmitted to (room #). Arrived by ambulance and stretcher. Information upon admission obtained from patient chart. Reason for admission is post-survey recent acute illness Rehabilitation...Call bell placed within reach. Physician notified/orders verified: Yes. See nursing admission assessment for detailed clinical findings." Written by RN (registered nurse) #1. The comprehensive care plan, dated, 5/22/15, documented, "Focus: Resident has actual skin breakdown related to shear/friction risks, vascular disease, limited mobility." The "Interventions" documented, "Evaluate wound area daily including surrounding tissue and presence or absence of drainage/infection and/or new wound pain and report to MD (medical doctor) as indicated. Monitor for effectiveness and/or side effects of medication. Monitor for verbal and nonverbal signs of pain related to wound or wound treatment and medicate as ordered." The "Skin Integrity Report" dated, 5/22/15, documented "Surgical" and documented for the right lateral foot surgical wound the following: "Presence of Pain - no Appearance - skin graft, 13 sutures, IP (intact/deep purple) deep red. Length - 10 (centimeters) Width - 3.5 Depth - na (not applicable) Drainage - na/ dry Surrounding tissue - IF/DP (inflamed/deep purple-maroon) Wound Edges - M (macerated) Odor - no." The "Skin Integrity Report" dated, 5/25/15, documented for the right lateral foot surgical wound the following: "Presence of Pain - no	F 309		

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F 309	Continued From page 17 Appearance - N (necrotic - eschar) with sutures in place Length - 10 (centimeters) Width - 3.5 Depth - left blank Drainage - na Surrounding tissue - IF (inflamed) Odor - (a zero with a line through it indicating 'no')." The nurse's note dated, 5/25/15 at 19:59 (7:59 p.m.) documented, "(Resident #1) transferred to hospital - unplanned for evaluation and treatment via ambulance to (initials of hospital) ER (emergency room). Physician notified of transfer (nurse practitioner name) 5/25/15 - 8 p.m. Responsible party notified of transfer Self/Daughter 5/25/15 at 8 p.m. Resident admitted to facility for right 4th/5th toes amputation with graft placement due to gangrene. Upon admission, graft site noted to be deep red/purple and to be somewhat dry. Over the weekend condition of wound worsened and is now noted to have layer of necrosis. Resident denies feeling pain (due to neuropathy). New orders to send resident to hospital for evaluation. Resident also on Zosyn (an antibiotic) and Vancomycin (an antibiotic) IV (intravenous) therapy." The nurse's note dated, 5/25/15 at 20:46 (8:46 p.m.) documented, "(Name of doctor who did skin graft - administrative staff member [ASM] #3, podiatrist) returned the call after the patient had been transferred out to the hospital. He was told that the wound vac had not been applied. (ASM #3, podiatrist) reminded writer that he had signed all the paperwork for the wound vac. (ASM #3) was also told that (the infectious disease physician) had been faxed the lab (laboratory) results showing that the Creatinine level	F 309		

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F 309	Continued From page 18 (indicating kidney function) was above 1.6 showing 1.63. (Name of nurse practitioner) had been called and made aware that RP (responsible party) was upset. Order was given to send the pt (patient) to (initials of hospital) ER for eval (evaluation)." The ER physician report dated, 5/25/15 at 20:59 (8:59 p.m.) documented, "Chief Complaint: complication with graft from gangrene. Severity is described as being, it has become recently worse. This started 2 days ago and is still present. Symptoms located in the area of the right root. The patient had not had redness. No swelling. Patient denies injury. Additional history - 64 year old female presents to ED (emergency department) from (Name of nursing facility) via EMS (emergency medical services) d/t (due to) possible graft necrosis x1 day. Pt had right 4th and 5th toes removed and a graft placed on 5/23/15 (*note this date is a discrepancy as the resident was discharged to the facility on 5/22/15 post placement of the graft) d/t gangrene. Pt reports bleeding x2 days from site and today the staff at (name of nursing home) noted a change in status of the wound. Pt reports she has not been on a wound vac since she was dc'd (discharged) from the hospital...Temp (temperature): 100.6 (normal is 98.6)." The attending physician history and physical dated 5/25/15, documented, "History of present illness: The patient was discharged from the hospital on 5/22/15 after coming in with cellulitis and gangrene of the right foot, it was found that she had osteomyelitis (infection of the bone) involving the right 4th and 5th toes post amputation. (ASM #3, the podiatrist) removed the 4th and 5th toes and performed some skin grafting over the proximal area of the right foot due to inability to have full closure. The patient	F 309		

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F 309	Continued From page 19 stated that she was supposed to have a wound VAC placed on her foot, although that never did occur and today when the wound nurse came in to do wound care, she noted that the skin graft had died, so the patient requested to be transferred to the hospital." The "Consultation Note" dated, 5/26/15, by ASM #3, the podiatrist, documented, "The patient is a 64 year-old, white female, who had an amputation of the 4th and 5th metatarsals (toes) of the right foot with skin graft placement last week. She was placed in (name of facility) on Friday. The Nursing Home decided not to place the wound VAC over the wound. Yesterday evening, she was admitted here with total necrosis of the graft at the lateral aspect of her right foot...Plan: Total debridement (surgical removal of devitalized tissue*) of the wound was discussed with the patient with placement of a new wound VAC. She is scheduled for the operating room tomorrow at 1:30 p.m." An interview was conducted with RN #1 on 6/4/15 at 3:02 p.m. When asked if Resident #1 came in with orders for a wound vac, RN #1 stated, "No, there were no orders for a wound vac." RN #1 was asked if she was aware of the resident's needs for a wound vac and that she had a skin graft. RN #1 stated, "The wound nurse alerted me that a resident was coming with a graft site. I evaluated the resident per our protocol for graft sites. The site was dry, deep, deep red with purple spots. My understanding is that a wound vac is put on nice healthy tissue. So I put on the oil emulsion dressing." When asked if she is certified in wound care, RN #1 stated, "No, the wound care nurse instructed me." When asked if she called a doctor to get those orders for the emulsion dressing, RN #1 stated, "No, we have orders to initiate treatment per our protocol."	F 309		

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F 309	Continued From page 20 When asked if she contacted the surgeon that did the skin graft, to inform him/her of the status of the wound, RN #1 stated, "No, I had a really busy night that night." An interview was conducted with ASM #3, the podiatrist who performed the amputation and skin graft, on 6/4/15 at 3:45 p.m. When asked if he had written out orders for the wound vac, ASM #3 stated, "The discharging physician writes the orders. I worked with the continuing care nurse at the hospital to fill in the forms for her insurance company to approve the wound vac. Everything was set in place with (name of manufacturing company of wound vacs). It was supposed to be at the facility when she arrived. The patient knew she was supposed to have a wound vac." ASM #3 was asked what knowledge he had of Resident #1's time at the facility. ASM #3 stated, "I spoke with a nurse on Monday (5/25/15) from the facility, (RN #2, the evening supervisor). She told me that the resident had orders for the wound vac and she doesn't know why the nurse didn't follow the orders. I saw the wound on Friday (5/22/15) morning. It had nice pink viable tissue; the granulation tissue was forming through the mesh. I had a wound vac on her for one week and it was doing great in the hospital. Why it was black on Monday night is from the wound vac not being applied as ordered. If they had a question about the wound, wouldn't you think they would contact the operating surgeon? Shouldn't they contact me and tell me my orders were changed? I had to take her back to the operating room to debride the graft and placed another wound vac. She will now have a recovery time of four months instead of four weeks. I am so concerned that no one called me. I am on call. I have an answering service. I take my own call unless I am out of town, I wasn't. There was no reason why I should	F 309		

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F 309	Continued From page 21 not have been contacted." On 6/4/15 at 4:04 p.m. RN #1 returned to this surveyor and stated, "I misunderstood what you asked. Every time I get orders we have to go through our doctors." When asked who she spoke with on 5/22/15 when Resident #1 arrived at the facility, RN #1 stated, "(Name of ASM #4 {on call physician}). If I don't talk to the doctor's then my supervisor does." When asked who spoke with ASM #4 on 5/22/15, RN #1 stated, "I talked to the on call doctor, (ASM #4)." On 6/4/15 at 4:08 p.m. an interview was conducted with the director of nursing (DON). The DON was asked what interactions or knowledge she had of Resident #1. The DON stated, "I was here on Memorial Day for a little bit. I answered her call bell and assisted her toileting and helped dress her. I didn't have any knowledge of the wound situation." When asked if RN #2, the evening supervisor, was available for interview, the DON stated RN #2 (evening supervisor) was out of the country on vacation. When asked if any nurse practitioner or doctor examined Resident #1's wounds prior to 5/25/15, the DON stated, "No." The on-call schedule for the physicians was reviewed for the month of May 2015. The nurse practitioner was documented as on call on 5/22/15, 5/23/15, 5/24/15 and 5/25/15. An interview was conducted with ASM #4, (the physician that RN #1 stated she had spoken to on 5/22/15), on 6/5/15 at 8:30 a.m. When asked if she was on call on 5/22/15, ASM #4 stated, "I don't think so." When asked if she recalled being on call for Memorial Day weekend, ASM #4 stated, "No, I was off that weekend." ASM #4 was asked when her on call rotation starts. ASM #4 stated, "On Friday after 5:00 p.m." ASM #4 was then asked if she recalled a conversation with RN	F 309		

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F 309	Continued From page 22 #1 on 5/22/15 regarding Resident #1's wound, a skin graft. ASM #4 stated, "I don't do wounds at all. I usually don't do any orders for them; the facility takes care of that." When asked what she does when there is any complicated wound, ASM #4 stated, "I talk to the Medical Director." ASM #4 was asked if the nurse brought to her attention a surgical wound concern, would she contact the surgeon who performed the surgery. ASM #4 stated, "Yes, if there is a concern with a surgical wound I would have them contact the surgeon." The facility policy, "Physician/Med-level Provider Notification" documented, " Upon identification of a patient who has a change in condition or abnormal lab (laboratory) values, a licensed nurse will perform appropriate clinical observations and data collection and report to physician/mid -level provider. If unable to contact attending physician/mid-level, the Medical Director will be contacted. Purpose: To communicate a change in patient's condition to physician/mid-level provider and initiate interventions as needed/ordered. " On 6/5/15 at 9:28 a.m. the DON was informed of above concerns. The administrator was not in the building at that time. When offered the time to present any further information regarding the above concern, the DON stated, "I don't have anything else to present." In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. BUILDING _____ B. WING _____	C 06/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 23 follow standards of care, to give competent health care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient. No further information was provided prior to exit. COMPLAINT DEFICIENCY (1)http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3379164/ *This information was obtained from the website: http://www.merriam-webster.com/dictionary/debridement	F 309		